MEDICAID CHANGES and IMPACT ON STATE AND COUNTY DOLLARS

Thank you for the opportunity to speak with you today. My name is Irene Blair, Webster County CPC. Today I am going to talk about Medicaid changes and the impact of those changes on county dollars and the need for increased funding of the system.

Medicaid funded services saved us (state & counties) money. Thank you for passing ARO, day habilitation, case management--all of those Medicaid services funded services for adults. While these programs have saved us state and county money, many of them are on the hit list for the feds and any push back there will have a major adverse impact on counties and thus increase the need for additional state or county money in the system if we are to maintain services.

Recently we have seen significant changes with Medicaid funded services. We can appreciate the urgency of complying with the Federal Deficit Reduction Act and the need to comply with Medicaid rules. But these changes, which seem to have been formed in a vacuum and often without the participation of other stakeholders, have had a major impact on the system.

I. Disincentives for Medicaid Providers

There have been new interpretations of rules for Medicaid services almost daily. Not only are there new interpretations almost daily, but there are also conflicting messages from various DHS staff, or their contracted provider agencies, nearly every day. Evidence of this is the one-year limit on pre-voc, the many different things providers and counties have been told about whether we can start habilitation services yet, and provider audits where providers are held to what is currently in the rules rather than what was in the rules when they billed. Providers are reluctant to provide the new services due to inconsistent messages and new interpretations of manual material—if there is a manual. Some providers chose to end providing ARO services early due to the threat if they are audited, they might have to pay back To continue providing services, we are using county dollars. Providers are being fined by the State for providing services to people with challenging behaviors who have eloped from the facility even though there was no injury or danger to the client. There is a shift from Medicaid funded services to county dollars due to the fear of paybacks. Recent Surveillance and Utilization Review Service (SURS) audits of prevocational service providers have determined that providers need to pay back 100% of the dollars during the audited timeframe. As one provider told me, "We are very leery about adding more Medicaid funded services. We're out on a limb with a chainsaw now". Another provider said, "It is getting harder and harder to follow rules, since so many seem to be unwritten and perhaps interpreted differently by various people." Some providers are saying they will not venture into Habilitation Services until there is a finalized manual and some training. Few providers have "taken a chance" on remedial services.

It is odd that at a time when the State voices a desire to rebalance the system, which would require more providers, they are seemingly doing many things that are a disincentive to providers.

II.Funding Concerns

Money Follows the Person Grant

Recently we read about the Money Follows the Person Grant (51 million dollars) that Iowa received. There are three modifications to the existing MR waiver which will support the demonstration. One of the modifications is that DHS will request that people with "related conditions" (including developmental disabilities) be included in the target populations served by the MR waiver. This will have major impact on county budgets if counties are mandated to pay the non-federal share of the waiver for people with developmental disabilities. Counties wholeheartedly support expansion of services to people with developmental disabilities so long as the money comes with the person.

Federal Medical Assistance Percentages (FMAP):

The non-federal share of Medicaid services, which counties pay continues to rise. On 10/1/05 we were paying 36.39% FMAP. On 10/1/07, we were paying 38.66% FMAP. But that is NOT a 2% change, it is a 6% increase in what we pay. Counties spend about $150 million on the non-federal share of Medicaid payments. A 6% increase in those costs equals $9 million. The legislature has appropriated a line item for FMAP changes when DHS pays the non-federal share. DHS has not requested, nor has the legislature appropriated, a similar adjustment when counties pay the non-federal share of Medicaid.

That's not the whole story though. When you add the impact of FMAP changes to ICF/MR rebasing last year, HCBS rebasing this year, and two years of 3% provider rate increases, we've seen our Medicaid costs go up 12% over the past two years. That means an increase of $18 million total impact to county budgets as a result of Medicaid increases. Allowable growth was only increased by $12.8 million during the past two years. In other words, the reason counties are cutting discretionary (100% county-funded services) is that Medicaid is eating up all of our growth money.

Some counties have not added slots for the MR waiver because they are out of funds. However, these counties find the number of people under the MR waiver increasing due to kids turning 18, who come into the adult system with a slot. Scott County limited slots to 350 in March of 2006. By June 30th of this year, they will have 363 people accessing HCBS/MR services. County budgets continue to grow and there is no additional money to cover the costs.

Mental Health Centers to be reimbursed cost of service by TXIX – effective Oct. 1, 2006

HF 2780 passed last year. A section of the bill increased Medicaid reimbursement effective 10/1/06 to mental health centers, inpatient psych units and psychiatrists.

Although this passed was to be effective October 1, 2006, it is yet to be implemented. DHS claims they must get the State Plan approved by the Feds before this is implemented, but nevertheless, we have not realized the potential savings that we planned on. This bill increased Medicaid reimbursement effective 10/1/06 for certain mental health providers in order to strengthen the mental health safety net by amending the state plan and Magellan contract using $5.8 million in one time state dollars. This has not happened and our mental health center has heard nothing from the state. We continue to subsidize Medicaid rates at mental health centers. For instance, for FY 06, the cost report shows an actual rate of $95.34 per hour of therapy but because of the low Medicaid rates, we pay $144 per hour of therapy. If we did not do this, our mental health center would cease to exist. Consequently, counties have not realized the potential savings.

Iowa Care – TXIX at the MHIs

County bills were not reduced even though the people served were supposedly now going to be covered by Medicaid. Is it legal for counties to subsidize a public hospital that is paid by Medicaid?

Conclusion:

Perhaps it is time to stop chasing the Medicaid dollar. In 1985, there was a shift from medical facilities to community services with the Katie Beckett waiver. The idea was to waive the requirement that Medicaid be used only for medical institutions such as hospitals and nursing homes with their strict regulations and allow people to receive services in their homes at a much reduced cost. We are now providing many services in the community with Medicaid dollars. But, it seems there has been a shift at the Federal level. There has been a resurrection of applying all of the onerous, clinical rules and regulations to these "waiver" services. Since the majority of the community "waiver" services are not clinical, much time is spent trying to understand how to PERFECTLY document non-clinical services by using clinical documentation standards. All of us who receive Medicaid dollars to provide services to people are so focused on paper and documenting everything correctly to escape fines and paybacks, we have lost sight of the person. How much of the cost of service is because of documentation? We have done some calculations that show that if we eliminated the Medicaid requirements for such nonsense as putting stickers with the client's name, birthdate, and ID on both sides of every document in the file, we would arrive at a cost of what is currently just our share of Medicaid. In other words, we could provide the same service without the nonsense, and do it without the federal dollars and headaches. If our focus shifted from paper back to the person, would we be serving the individual better? We need to evaluate if we should continue providing services with Medicaid dollars. Perhaps we could meet the needs of individuals better with state and county dollars. **BUT, whether we use Medicaid dollars or not, more money is needed in the system.**

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